

NOV 24 1930

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

32725

1. PLACE OF DEATH

County *Yell*
Township *Liberty*
City *Yell*

Registration District No. *372*
Primary Registration District No. *5-179*

File No. _____
Registered No. *686*
St. _____ Ward)

2. FULL NAME

(a) Residence No. _____ St. _____ Ward. _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

John Hall Cantline

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male*
4. COLOR OR RACE *White*
5. SINGLE, MARRIED, WIDOWED OR DIVORCED *Widowed*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Mary Susan Cantline*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *July 25 - 1850*

7. AGE YEARS MONTHS Dns If LESS than 1 day, hrs. or min.
80 . 7 . 27

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work *Farmer*
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Maryland*

10. NAME OF FATHER *Archam Cantline*

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Dunkirk*

12. MAIDEN NAME OF MOTHER *Unknown*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

14. INFORMANT *Mrs Russell Wilson*
(Address) *Mound City Mo.*

15. FILED *10-28-30* *J. O. Fisher* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *Oct 22 1930*

17. I HEREBY CERTIFY, That I attended deceased from *July 20*, 1930, to *Oct 22*, 1930, and that I last saw him alive on *Oct 20*, 1930, and that death occurred, on the date stated above, at *11:23 P. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic nephritis with cardiac decompensation
131
11:23 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *acute pulmonary edema* (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?
NOT AT PLACE OF DEATH

19. DID AN OPERATION PRECEDE DEATH? *NO* DATE OF _____

20. WAS THERE AN AUTOPSY? *NO*
WHAT TEST CONFIRMED DIAGNOSIS? *Laboratory*
(Signed) *F. G. Hagan* M. D.

10-23-30 (Address) *Mound City Mo*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL *New Liberty* DATE OF BURIAL *10/24 1930*

20. UNDERTAKER *H. H. Crawford* ADDRESS *Mound City Mo*

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

